Five Oregonians to Remember

Charles J. Bentz MD, FACP

January 9, 2008

Wisconsin is facing legislation similar to Oregon's Death with Dignity Law. While pro-suicide groups cite the "great success" of the Oregon experience, everyone in Wisconsin needs to hear the real record. Here are the cases of five Oregonians, all part of the public record, for whom the tragedy of doctor-assisted suicide was all too real.

Patients with dementia are being killed: The case of Kate Cheney

Mrs. Kate Cheney was an elderly Oregon woman with growing dementia and a diagnosis of a potentially terminal cancer. Her daughter, Erika, asked her primary physician for assisted suicide. This physician found the patient incompetent and denied this initial request. A second opinion was obtained by a psychiatrist who found that Mrs. Cheney had short-term memory deficits and dementia, and that this assisted suicide request appeared to be the daughter's "agenda." The daughter, who also accompanied Mrs. Cheney to this appointment, "coached her" in her answers, even when the psychiatrist asked her not to do so. Concerning the patient, the psychiatrist observed, "She does not seem to be explicitly pushing for this." Thus, the psychiatrist concluded that the patient lacked sufficient capacity to weigh options about assisted suicide and she was ineligible for doctor-assisted suicide. The daughter, however, would not take 'no' for an answer, and sought a second mental health evaluation where the patient could not even remember when she was diagnosed with terminal cancer, although it had only been within the last three months. It was noted by this second mental health opinion that the patient's "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive". The pressure directed at Ms. Cheney from her family was so great that her own motivations could not clearly be distinguished from those of her daughter's. Despite these facts, this Kaiser patient had a home visit by her "managed care" administrator who decided she was a good candidate for assisted suicide and sought out a physician who could write for a lethal prescription. Fifteen days later she died from this lethal barbiturate overdose, and this 'psychiatric evaluation' was no protection for her.

Depressed patients are given the means to commit suicide: The case of Michael Freeland

Michael Freeland, a 63-year-old cancer patient, had been haunted by thoughts of suicide since his early 20's when he made his first suicide attempt. In March 2000, his doctor diagnosed him with lung cancer and the following year he sought out, and was given a lethal dose of medication by a 'Compassion & Choices' physician. Subsequently, Mr. Freeland was hospitalized with depression and because of both suicidal and homicidal thoughts. The attending psychiatrist, declared that Mr. Freeland was incompetent and said "The guns are now out of the house, which resolves the major safety issue." Yet, the same report claimed, "He keeps this [the lethal barbiturate overdose] safely at home." Two weeks before his death, members of Physicians for Compassionate Care (PCC), an organization which promotes palliative care, found Mr. Freeland alone, in pain, dehydrated, and suffering from painful constipation. He was depressed, confused, and afraid to take his pain medication and was about to take the lethal overdose because of pain. He had called his suicide doctor and this "Compassion & Choices' physician offered to sit with him while he took the lethal overdose. The PCC members, on the

other hand, encouraged him to take his pain medication and arranged for 24-hour attendant and receive an infusion pump for better pain care. Several weeks later, Mr. Freeland died comfortably, just having reconciled with his daughter and without taking the lethal drugs.

Patients are euthanized in the name of 'assisted-suicide': The case of Clarietta Day.

Dr. Gallant saw an unconscious patient in the Corvallis Emergency Department who had suffered a stroke. The patient's daughter decided that her mother would be better off dead and asked Dr. Gallant to remove life support. He did so but the patient kept breathing. He then gave serial doses of valium and morphine to this unconscious patient (in no pain) trying to stop her breathing. This didn't work. Then he placed a magnet over her pacemaker in a deliberate effort to stop her heart. This, too, did not cause her to die. He then gave her a massive dose of succinylcholine, a drug that paralyzes all of the body's muscles including the breathing muscles. This medication should not be given any patient unless breathing is supported artificially because it will paralyze all of the body's breathing muscles, as it did in this case. The patient died within minutes of being deliberately and completely paralyzed by Dr. Gallant. The Oregon Board of Medical Examiners chose to reprimand Dr. James Gallant for unprofessional and dishonorable conduct and suspended his license for 60 days for engaging in active euthanasia with respect to his patient, Clarietta Day, who died as a result of a lethal injection administered by a nurse. No criminal charges were ever filed in connection with the patient's death and this doctor continues to practice. The Oregonian, in reporting on this act of active involuntary euthanasia, called Dr. Gallant's action a "case of assisted suicide".

Nurses are now getting into the act: The case of Wayne Melcher

Two nurses gave an overdose to a patient, Wayne (Wendy) Melcher, who had throat cancer. One nurse admitted that she was following the "plan" that had been developed by the patient for his own suicide. The nurses acted independently without following hospice protocol or even asking for any physician directive or order in giving overdoses of two different drugs . This assisted suicide effort was never reported to the Oregon Health Division as is required by the assisted suicide law. As one of the nurses is reported to been having a relationship with Melcher's significant other, there is a clear conflict of interest. After this action of direct and intentional medical killing, these two nurses continue to practice in the State of Oregon.

Attempts at assisted suicide are failing: The case of David Pruitt

David Pruitt, a man from Oregon with lung cancer, obtained from a physician the standard lethal overdose by prescription, and when he felt it was time, he took the entire amount. He went to sleep for 65 hours and woke up saying "What the hell happened? Why am I not dead?" He was so unnerved by the experience that he didn't want to go through it again. He died naturally nearly two weeks later.

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Why remember these 5 Oregonians?

The annual reports from Oregon's Department of Human Services need to be interpreted cautiously because reporting is voluntary and only assisted suicide enthusiasts report. Oregon DHS officials have acknowledged that all of the reported information may be "cock and bull" for all they know. We may never fully understand what has gone on with other cases as Oregon DHS officials have acknowledged in writing that they have actually destroyed identifying information in the name of "privacy" and in what many others have called a "shroud of secrecy."

The facts in these five Oregon cases are part of the public record and beyond dispute. Clearly, all is not well in Oregon and the statements by the proponents of physician-assisted suicide (that everything is going well) are patently false and deliberately deceptive. In all likelihood, these five tragically flawed cases represent only the tip of the iceberg of those who have been directly or indirectly harmed by this misguided law.

Wisconsin needs the full story of how Oregonian's lives are being adversely affected by the assisted suicide law. This law has created an environment where demented and depressed patients are medically killed, nurses are taking matters into their own hands, and involuntary euthanasia is being practiced in the name of assisted suicide.

Wisconsin needs to know that doctors in Oregon continue to stand in opposition to the practice because of the inherent conflict of interest for the medical profession and for society.

- Doctor assisted suicide undermines trust in the patient-physician relationship
- Doctor assisted suicide changes the role of the physician in society from the traditional role of healer to that of the executioner
- Doctor assisted suicide endangers the value that society places on life, especially for those who are most vulnerable and who are near the end of life.

Respectfully submitted,

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Testimony of Susan Armacost
Legislative Director
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in opposition to SB 151

before the Senate Committee on Public Health,
Long Term Care and Privacy

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Wisconsin Right to Life urges you to oppose SB 151. This extremely onerous legislation would legalize the killing of vulnerable patients by allowing their physicians to prescribe lethal doses of drugs so the patients can kill themselves.

Wisconsin Right to Life is in the forefront on both the state and national levels in opposing measures that would legalize physician assisted suicide and euthanasia and in assisting other states facing such legislation.

Wisconsin Right to Life and Christian Life Resources founded the Nightingale Alliance and maintain a website devoted entirely to the issues of assisted suicide and euthanasia. The Nightingale Alliance is a worldwide information resource on these topics and can be accessed at NightingaleAlliance.org We urge you to visit this excellent website.

We must guard against those 'choices' which victimize the vulnerable, ourselves, and society as a whole. We must minister compassionately to those who suffer from pain and those who fear death. Doctors should heal, not kill. We must maintain the healing tradition of medicine.

Supporters of assisted suicide and euthanasia argue that the right of a competent patient to make medical treatment decisions should include the right to request and receive euthanasia or to be assisted with suicide. There are dangers, however, even when patients are allowed to "freely" request assisted suicide or euthanasia.

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Some of these dangers are:

- Patients are misdiagnosed and could make an irreversible decision to die based on the wrong information.
- A government-ordered study in the Netherlands found that 65% of family physicians are of the opinion that a doctor may offer the choice of euthanasia to a patient who has not asked for it.
- Because patients are strongly influenced by doctors, a vulnerable patient may feel there is no other alternative if his or her doctor recommends death.
- Who can confirm that the euthanasia or suicide choice was freely made when the only witness is dead?
- Patients with terminal or serious illnesses change their minds. When they don't feel well, they may want to die. When feeling better, they want to live.
- Patients suffering from depression may request death, not knowing that their quality of life can be improved with proper treatment.
- If society endorses assisted suicide and euthanasia, it will "teach" the weak and frail that they have a "duty" to die.
- The collapse of support systems will lead patients to believe they have no other choice but death.
- Although some believe assisted suicide and euthanasia are needed to relieve pain, modern pain control techniques eliminate this reason.

Wisconsin Right to Life urges you to oppose SB 151. Thank you.

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Against Physician Assisted Suicide Paul B. Young, MD, MA-Bioethics

Physician assisted suicide does a variety of things which are wholly undesirable:

1) At the level of the society, physician assisted suicide is a threat to both the doctor and the patient. Illness renders a patient very vulnerable. Physically, mentally, and emotionally, they are at their weakest. Likewise, the physician, by virtue of his knowledge and skill, is in a relative position of strength. The patient must necessarily leave his or herself open bodily and often disclose the most intimate details of their life. The physician is given this privilege for the sole purpose of helping the patient wrestle with disease. There is an inherent imbalance of power in a therapeutic relationship between a doctor and patient than can never be eliminated. It is intrinsic to the nature of illness and treatment. Western medical ethics long ago recognized this vulnerability and imbalance and created safeguards to deal with it. Physicians are prohibited from exploiting patients financially or sexually. They are required to keep all that is told to them in absolute confidence. Above all else, the physician is prohibited from ever intentionally harming the patient. These safeguards serve to protect the patient, create the trust necessary to form a therapeutic alliance, and lastly assure that the physician will serve only the patient's interest. Legislation promoting physician assisted suicide destroys this most important safeguard. By creating a right to assistance in self destruction, the doctor is now obligated to act in a manner contrary to the basic principle of medicine ***"primum no nocere...first, do no harm."*** Worse still, he or she now has a duty required by law to participate in an enterprise which is morally bankrupt regardless of any invitation, namely assisting in the deliberate taking of an innocent human life.

2) Physician assisted suicide at the clinical level undermines the very essence of good medicine. Medicine always involves two distinct and equally important goals. The first of these is to maximize the health and well being of the patient. The second is to reduce or alleviate suffering caused by disease, and to provide comfort and human connection to those dealing with illness. The chronically ill or dying patient is often overwhelmed by fear, loss, and isolation. They suffer not only physical pain, but emotional anguish over their loss of independence and ability. Often family members, in the process of dealing with their own grief, withdraw from the patient. It is not surprising, therefore, that these patients frequently become depressed and suicidal. Good palliative care remedies this situation by this by maximizing pain control and improving day to day functioning, treating depression, and offering physical, spiritual and emotional support. It helps the patient work through the end of life process. Physician assisted suicide circumvents this dynamic. It affirms the patient's worst fears and offers no good solution to the problems facing the patient. Physician assisted suicide is not treatment; it is abandonment.

What are good goals for public policy regarding the care of those facing chronic or terminal illness?

The single greatest pressure on healthcare today is financial. As we seek to grapple with the staggering costs of healthcare, we need to avoid undermining the very ethical principles that promote good patient care. If we allow physician assisted suicide, we may find out that we have effectively limited our approach to the palliation of chronic illness. Unfortunately, it is cheaper to help a patient to die than to provide good end of life care. Physician assisted suicide could encourage a patient to die as a "duty" to his or her family, in the face of financial pressure. Likewise doctors could find their end of life care options curtailed by third party payers, or offered economic incentive to allow a suicide. As society ages, this could become a national tragedy. We need to fund good palliative care treatment practices. We need to insist as a society that our physicians are adequately trained in managing pain, and that palliative care be an ongoing part of medical education and research. Mechanisms to communicate desired treatment options (e.g., desire for or against life prolonging technology, cardiac resuscitation, etc.) continue to need refinement. Orders and instructions that can be updated as the patient's condition changes need to be available in every setting, including home, nursing facility, or hospital. Lastly, we should affirm the traditional protections offered patients in western medical ethics. As the face of healthcare continues to change in Wisconsin and across the nation, no patient should fear that their physician would attempt to harm them under any circumstance, even if asked during a crisis of pain or fear.

What does good end of life care look like clinically?

The best practices in end of life care work to maximize the life of the patient. Instead of trying to determine if the patient's life is so poor that it should be ended, good palliative care looks to understand how the patient's life goals, comfort, and function can be improved. It always focuses on the whole person and the family. Early in a terminal illness, this may involve identifying things the patient wishes to accomplish before dying and facilitating those desires. Later as illness advances, the focus may increasingly shift to pain and symptom control, comfort measures, and emotional and spiritual support. Good end of life treatment plans do not necessarily attempt to prolong the dying process, but support the patient and their loved ones through the illness. While it is not uncommon for chronically ill patients to express fear, a sense of deep loss, loneliness, isolation, and a desire to die, good supportive care often alleviates these problems. Once the needs are addressed, the desire to end life prematurely usually subsides. A plea to die is really a cry for help. What is needed is support.

On a personal note

In addition to being a physician and ethicist, I was also a son. My father died of chronic congestive heart failure, which claimed his life after 10 years with the disease. In his last months he spent much of his time in bed, on oxygen, and was able to walk only short distances. He experienced near miss events twice, including at least one full arrest requiring CPR. As I walked with him through that time, I saw how he faced his disease with strength and fortitude. His last act as my father was to receive downstairs to say goodbye and walk me to the front door, which required great effort. I learned from him that dying requires enormous courage, not only for yourself but those around you.

My mother faithfully cared for my dad through this time, and his death left her struggling with depression for her remaining 5 years. She experienced excruciating spinal fractures from brittle bones, and multiple surgeries for hip replacements. She was dependent on narcotics to get through each day. If her symptoms were bad, or her depression flared, she would become despondent. However, the family would rally behind her and once she received the support she needed, her sadness faded.

In 1993, she developed an acute bowel obstruction, and underwent surgery. Unfortunately, the stress of the illness and surgery proved too much. She developed multi-system organ failure a few days following her operation, which caused her lungs to fill with fluid, her kidneys to shut down, and her coagulation system to consume itself. I had been asked by her some years before to serve as her power of attorney should she become incapacitated, and I found myself faced with the terrible predicament of making decisions on her behalf.

She had always been clear that, in the event her chances of recovery were poor, life support on a ventilator was not an option. She had long experienced chronic pain, and hated the prospect of extended nursing care. If there was a strong likelihood that a survival could be obtained only with an extended disability, she wanted no part of it. After looking over her medical chart and talking with her physicians, we agreed to a care plan that did not include further ICU treatment. She died three days later.

While I respected my mother's decisions to avoid ICU treatment at the end of life, at no time would I have offered to harm my mother. While she often wished for suffering in this life to end, she never attempted to harm herself or asked for our assistance to do so. In part, I think because she got the help she needed it never came to that (at least not for long, anyway). I believe also that she loved us enough to never ask us to do such a thing.

Suffering, illness, and death are hard things. I believe you make them better by standing with people through them. If you don't give up on them, they won't give up. I think that's what death with dignity really means.

NINE YEARS OF ASSISTED SUICIDE IN OREGON

Under Oregon's law permitting physician-assisted suicide, the Oregon Department of Human Services (DHS) – previously called the Oregon Health Division (OHD) – is required to collect information, review a sample of cases and publish a yearly statistical report.[1] Since the law, called the "Death with Dignity Act," went into effect in 1997, nine official reports have been published. However, due to major flaws in the law and the state's reporting system, there is no way to know for sure how many or under what circumstances patients have died from physician assisted suicide.

Statements made by individuals who have been involved in assisted suicide in Oregon – those who implement it, compile official reports about it, or prescribe the lethal drugs – clearly show that the law's "safeguards" are not protective and that effective monitoring is close to non-existent.[2]

Members of a British House of Lords Committee traveled to Oregon seeking information regarding Oregon's assisted-suicide law for use in their deliberations about a similar proposal that was under consideration in Parliament.[3] The public and press were not present during the closed-door hearings. However, the House of Lords published the committee's proceedings in three lengthy volumes, which included the exact wording of questions and answers.

Statements from portions of the 744-page second volume of those proceedings are included in this fact sheet. None of those included statements were made by opponents of Oregon's law.

Assisted-suicide deaths reported during the first nine years

Official Reports: 292
Actual number: Unknown

The latest annual report indicates that reported assisted-suicide deaths have increased by more than 287% since the first year of legal assisted suicide in Oregon.[4] The numbers, however, could be far greater. From the time the law went into effect, Oregon officials in charge of formulating annual reports have conceded "there's no way to know if additional deaths went unreported" because Oregon DHS "has no regulatory authority or resources to ensure compliance with the law."[5]

The DHS has to rely on the word of doctors who prescribe the lethal drugs.[6] Referring to physicians' reports, the reporting division admitted: "For that matter the entire account [received from a prescribing doctor] could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves."[7]

The Death with Dignity law contains no penalties for doctors who do not report prescribing lethal doses for the purpose of suicide.

Complications occurring during assisted suicide

Official Reports: 17 (16 instances of vomiting & 1 patient who did not die from the lethal dose)

Actual number: Unknown

Prescribing doctors may not know about all complications since, over the course of nine years, physicians who prescribed the lethal drugs for assisted suicide were present at only 21.5% of reported deaths.[8] Information they provide might come from secondhand accounts of those present at the deaths[9] or may be based on guesswork.

When asked if there is any systematic way of finding out and recording complications, Dr. Katrina Hedberg who was a lead author of most of Oregon's official reports said, "Not other than asking physicians."[10] She acknowledged that, "after they write the prescription, the physician may not keep track of the patient."[11] Dr. Melvin Kohn, a lead author of the eighth annual report, noted that, in every case that they hear about, "it is the self-report, if you will, of the physician involved."[12]

Complications contained in news reports are not included in official reports

- Patrick Matheny received his lethal prescription from Oregon Health Science University via Federal Express. He had difficulty when he tried to take the drugs four months later. His brother-in-law, Joe Hayes, said he had to "help" Matheny die. According to Hayes, "It doesn't go smoothly for everyone. For Pat it was a huge problem. It would have not worked without help."[13]

  Referring to the Matheny case, Dr. Hedberg said that "we do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted..."[14] The annual report did not take note of this situation.

- Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett described a botched assisted suicide. "The man was at home. There was no doctor there," she said. "After he took it [the lethal dose], he began to have some physical symptoms. The symptoms were hard for his wife to handle. Well, she called 911. The guy ended up being taken by 911 to a local Portland hospital. Revived. In the middle of it. And taken to a local nursing facility. I don't know if he went back home. He died shortly – some....period of time after that...."[15]

  Overdoses of barbiturates are known to cause vomiting as a person begins to lose consciousness. The patient then inhales the vomit. In other cases, panic, feelings of terror and assaultive behavior can occur from the drug-induced confusion.[16] But Barrett would not say exactly which symptoms had taken place in this instance. She has refused any further discussion of the case.

Complications are not investigated

- David Prueitt took the prescribed lethal dose in the presence of his family and members of Compassion & Choices. [Note: In early 2005, Compassion in Dying (CID) merged with the Hemlock Society. The combined organization is now called

Compassion & Choices (C & C).] After being unconscious for 65 hours, he awoke. It was only after his family told the media about the botched assisted suicide that C & C publicly acknowledged the case.[17] DHS issued a release saying it "has no authority to investigate individual Death with Dignity cases."[18]

- Referring to DHS's ability to look into complications, Dr. Hedberg explained that "we are not given the resources to investigate" and "not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."[19]

- David Hopkins, Data Analyst for the Eighth Annual Report said, "We do not report to the Board of Medical Examiners if complications occur; no, it is not required by law and it is not part of our duty."[20]

In the Netherlands, assisted-suicide complications and problems are not uncommon. One Dutch study found that, because of problems or complications, doctors in the Netherlands felt compelled to intervene (by giving a lethal injection) in 18% of cases.[21] This led Dr. Sherwin Nuland of Yale University of Medicine to question the credibility of Oregon's lack of reported complications. Nuland, who favors physician-assisted suicide, noted that the Dutch have had years of practice to learn ways to overcome complications, yet complications are still reported. "The Dutch findings seem more credible [than the Oregon reports]," he wrote.[22]

Similarly, a member of the British Parliament questioned the lack of reported complications associated with assisted suicide in Oregon. After hearing witnesses from Oregon claim that there had been no complications (other than "regurgitation") associated with more than 200 assisted-suicide deaths, Lord McColl of Dulwich, a surgeon, questioned that assertion. He said that, in his practice as a physician, "If any surgeon or physician had told me that he did 200 procedures without any complications, I knew he possibly needed counseling and had no insight. ***We come here and I am told there are no complications. There is something strange going on.***"[23]

Assisted-suicide deaths of patients with dementia

Official Reports: 0 (Official reports do not contain this category.)
Actual number: Unknown

- Kate Cheney, 85, died of assisted suicide under Oregon's law even though she reportedly was suffering from early dementia. Her own physician declined to provide the lethal prescription. When counseling to determine her capacity was sought, a psychiatrist determined that she was not eligible for assisted suicide since she was not explicitly seeking it, and her daughter seemed to be coaching her to do so. She was then taken to a psychologist who determined that she was competent but possibly under the influence of her daughter who was "somewhat coercive." Finally, a managed care ethicist who was overseeing her case determined that she was qualified for assisted suicide and the drugs were prescribed.[24]

- Even if a patient is competent when the prescription is written, that may not be the case when the lethal drugs are taken. Dr. Hedberg acknowledged that there is no assessment of patients after the prescribing is completed. "Our job is to make sure

that all the steps happened *up to the point the prescription was written*,"[25] she said. "In fact, after they write the prescription, the physician may not keep track of that patient....[T]he law itself only provides for writing the prescription, *not what happens afterwards*."[26]

Assisted-suicide deaths of depressed patients

Official Reports: 0 (Official reports do not contain this category.)
Actual number: Unknown

- The first known assisted-suicide death under the Oregon law was that of a woman in her mid-eighties who had been battling breast cancer for twenty-two years. Two doctors, including her own physician who believed that her request was due to depression, refused to prescribe the lethal drugs. Then Compassion in Dying (CID), now called Compassion and Choices, became involved. Dr. Peter Goodwin, medical director of CID,[27] determined that she was an "appropriate candidate" for death and referred her to a doctor who provided the lethal prescription. In an audiotape, made two days before her death and played at a CID press conference, the woman said, "I will be relieved of all the stress I have."[28]

- In 2001, Dr. Peter Reagan, an assisted-suicide advocate affiliated with CID, gave Michael Freeland a prescription for lethal drugs under Oregon's law. Freeland, 64, had a 43-year history of acute depression and suicide attempts. However, when Freeland and his daughter went to see Dr. Reagan about arranging a legal assisted suicide, Reagan said he didn't think that a psychiatric consultation was "necessary."[29]

Under the assisted-suicide law, depressed or mentally ill patients can receive assisted suicide if they do not have "impaired judgment."[30] Concerning the decision to refer for a psychological evaluation, Dr. Kohn said, "According to the law, it's up to the docs' discretion."[31] During the last year for which reports are available, only 4% of patients were referred for a psychological evaluation or counseling before receiving a prescription for assisted suicide.[32]

Assisted-suicide requests based on financial concerns

Official Reports: 7
Actual number: Unknown

Data about reasons for requests is based on prescribing doctors' understanding of patients' motivations. It is possible that financial concerns were much greater than reported. According to official reports, 36% of patients whose deaths have been reported since the law went into effect were on Medicare (for senior citizens) or Medicaid (for the poor) and an additional 1% had no insurance.[33] However, after the second annual report, the reports have not differentiated between Medicare and Medicaid patients dying from assisted suicide. Oregon's Medicaid program pays for assisted suicide[34] but not for many other medical interventions that patients need and want.

According to a December 2006 report, Oregon's Medicaid program has eliminated much of its available treatments. Fewer people are covered and enrollment has dropped by 17

percent.[35] When the program began, 745 possible treatments were listed in order of priority. Based on budgetary constraints, the state makes a determination of a cut-off line on the priority list. Treatments below the cut-off line are not provided. However, physician-assisted suicide is high on the priority list. (It is ranked 262 and falls under the category of "comfort care."[36]) It could become the only "treatment" some people can afford.

Patients who received lethal dose more than 6 months before death

Official Reports: 2 or 4 (After the 2nd year, official reports stopped including this category.)
Actual number: Unknown

Lethal prescriptions under the Oregon law are supposed to be limited to patients who have a life expectancy of six months or less.[37]

- However, one patient was still alive 17 months after the lethal drugs were prescribed,[38] and, during the first two years of the law's implementation, at least one lethal dose was prescribed more than eight months before the patient took it.[39] The DHS is not authorized to investigate how physicians determine their patients' diagnoses or life expectancies.[40]

- According to the Oregon Medical Association's Chief Operating Officer, Jim Kronenberg, most physicians have told him that trying to predict that a patient has less than six months to live "is a stretch." "Two hours, a day, yes, but six months is difficult to do," he explained.[41]

- Dr. Peter Rasmussen, an advisory board member of the Oregon chapter of C &C,[42] has been involved in Oregon assisted-suicide deaths numbering into double digits. He said life expectancy predictions for a person entering the final phase of life are inaccurate. He dismissed this as unimportant, saying, "Admittedly, we are inaccurate in prognosticating the time of death under those circumstances, *we can easily be 100 percent off, but I do not think that is a problem.* If we say a patient has six months to live and we are off by 100 percent and it is really three months or even twelve months, I do not think the patient is harmed in any way...."[43]

Shortest length of time reported for prescribing doctor-patient relationship

Official Reports: Less than one week
Actual number: Unknown

Oregon's assisted-suicide law requires that at least two weeks elapse between the patient's first and last requests for lethal drugs.[44] Nonetheless, for the third through the ninth years, the doctor-patient relationship in some reported assisted-suicide cases was under one week.[45] Thus, official reports indicate that either some physicians are not complying with the two-week requirement or they step in to write an assisted-suicide prescription after other physicians refused.

Dr. Hedberg stated that there have been a number of cases over the years in which guidelines were not followed, including cases where doctors prescribed the lethal drugs without waiting for fifteen days as the law requires.[46]

First physician asked agreed to write prescription

Official Reports: 27 (41%) in the first three years (After the 3rd year, official reports stopped including this category.)

Actual number: Unknown

"Many patients who sought assistance with suicide had to ask more than one physician for a prescription for lethal medication."[47] Patients or their families can "doctor shop" until a willing physician is found. There is no way to know, however, why the previous physicians refused to lethally prescribe (i.e., the patient was not terminally ill, had impaired judgment, etc.) since non-prescribing physicians are not interviewed for the official state reports. The only physicians interviewed for official reports are those who actually wrote lethal drug prescriptions for patients.[48]

The unwillingness of many physicians to write lethal prescriptions led one HMO to issue a plea for physicians to facilitate assisted suicide and has also resulted in an assisted-suicide advocacy organization's involvement in most assisted-suicides cases.

HMO's efforts to facilitate assisted suicide

On August 6, 2002, Administrator Robert Richardson, MD, of Oregon's Kaiser Permanente sent an e-mail to doctors affiliated with Kaiser, asking doctors to contact him if they were willing to act as the "attending physician" for patients requesting assisted suicide. According to the message, the HMO needed more willing physicians because, "Recently our ethics service had a situation where no attending MD could be found to assist an eligible member in implementing the law for three weeks...."[49]

Gregory Hamilton, MD, a Portland psychiatrist pointed out that the Kaiser message caused concern for several reasons. "This is what we've been worried about: Assisted suicide would be administered through HMOs and by organizations with a financial stake in providing the cheapest care possible," he said. Furthermore, despite promoters' claims that assisted suicide would be strictly between patients and their long time, trusted doctors, the overt recruitment of physicians to prescribe the lethal drugs indicated that those claims were not accurate. Instead, "if someone wants assisted suicide, they go to an assisted-suicide doctor – not their regular doctor."[50]

Kaiser's Northwest Regional Medical Director Allan Weiland, MD, called Hamilton's comments "ludicrous and insulting."[51] However, it appears that Hamilton was correct, as the involvement of an assisted-suicide advocacy group indicates.

Assisted-suicide advocacy group involved in majority of assisted-suicide deaths

If a physician opposes assisted suicide or believes the patient does not qualify under the law, C & C or its predecessor organizations has often arranged the death. According to Dr. Peter Goodwin, the group's former medical director, about 75% of those who died using Oregon's assisted-suicide law through the end of 2002 did so with the organization's assistance.[52] During the 2003 calendar year, it was involved in 79% of such deaths.[53] According to Dr. Elizabeth Goy of Oregon Health Science University, the assisted-suicide advocacy organization sees "almost 90% of requesting Oregonians."[54]

.....

OTHER TROUBLING ASPECTS OF ASSISTED SUICIDE IN OREGON

No family notification required before a doctor helps a loved one commit suicide

Family notification is only recommended, but not required, under Oregon's assisted-suicide law.[55] The first time that a family learns that a loved one was considering suicide could be after the death has occurred.

Prescribing doctors decide what "residency" means

Under Oregon's law, a patient must be a resident of Oregon. Residence can be demonstrated by means that include, but are not limited to, a driver's license or a voter registration.[56] According to Dr. Hedberg, "It is up to the doctor to decide" whether the person is a resident. There is no time element during which one must have lived in Oregon. "If somebody really wanted to participate, they could move from their home state," she said. "I do not think it happens *very much*..."[57]

Pain control has become increasingly inadequate in Oregon

As of 2004, nurses reported that the inadequacy of meeting patients' pain needs had increased "up to 50 percent even though the emphasis on pain management has remained the same or is slightly more vigorous...Most of the small hospitals in the state do not have pain consultation teams at all," said Sue Davidson of the Oregon Nurses Association.[58]

.....

As other states and countries consider Oregon-type laws, it remains to be seen whether decision-makers will rely on the deceptively rosy picture painted by assisted-suicide supporters – or on the reality of the Oregon experience.

Endnotes:

[1] ORS 127.865 §3.11.

[2] See: "The Oregon Experience" at: http://www.internationaltaskforce.org/orexp.htm.

[3] On May 12, 2006, the British proposal was defeated in the House of Lords by a vote of 148-100.

[4] DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Prescription History." (http://www.oregon.gov/DHS/ph/pas/docs/prescriptionhistory.pdf)

[5] Linda Prager, "Details emerge on Oregon's first assisted suicides," *American Medical News,* Sept. 7, 1998.

[6] Joe Rojas-Burke, "Suicide critics say lack of problems in Oregon is odd," *Oregonian*, Feb. 24, 2000.

[7] Oregon Health Division, *CD Summary*, vol. 48, no. 6 (March 16, 1999), p. 2. (http://www.ohd.hr.state.or.us/chs/pas/pascdsm2.htm)

[8] DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, Table I. (http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf) The annual report states that the presence of the attending physician in 63 out of 292 reported deaths is 29%, however the calculation is mathematically inaccurate. The correct calculation is 21.5%.

[9] DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Methods." (http://www.oregon.gov/DHS/ph/pas/docs/Methods.pdf)

[10] Testimony of Dr. Katrina Hedberg before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*, Apr. 4, 2005, p. 263, question 597. (Hereafter referred to as *HL.*) Available at: http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf. (Last accessed Apr. 23, 2007.)

[11] Ibid., p. 259, question 567.

[12] Testimony of Dr. Melvin Kohn, *HL*, p. 263, question 598.

[13] Erin Hoover, "Dilemma of assisted suicide: When?" *Oregonian*, January 17,1999 and Erin Hoover, "Man with ALS makes up his mind to die," *Oregonian*, March 11, 1999.

[14] Testimony of Dr. Katrina Hedberg, *HL*, p. 267, question 621.

[15] Audio tape on file with author. Also see Catherine Hamilton, "The Oregon Report: What's Hiding behind the Numbers?" *Brainstorm*, March 2000 (http://www.brainstormnw.com); David Reinhard, "The pills don't kill: The case, First of two parts," *Oregonian*, March 23, 2000 and David Reinhard, "The pills don't kill: The cover-up, Second of two parts," *Oregonian*, March 26, 2000.

[16] Johanna H. Groenewoud *et al*, "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands," 342 *New England Journal of Medicine* (Feb. 24, 2000), pp. 553-555.

[17] Associated Press, "Assisted suicide attempt fails," March 4, 2005.

[18] DHS news release, "No authority to investigate Death with Dignity case, DHS says," March 4, 2005.

[19] Testimony of Dr. Katrina Hedberg, *HL,* p. 266, question 615.

[20] Testimony of David Hopkins, *HL*, p. 259-260, question 568.

[21] *Supra* note 16.

[22] Sherwin Nuland, "Physician-Assisted Suicide and Euthanasia in Practice," 342 *New England Journal of Medicine* (February 24, 2000), pp. 583-584.

[23] Remarks by Lord McColl of Dulwich, a member of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *HL*, p. 334, question 956. (Emphasis added)

[24] Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

[25] Testimony of Dr. Katrina Hedberg, *HL*, p. 259, question 566. (Emphasis added.)

[26] *Ibid.,* p. 259, question 567. (Emphasis added.)

[27] Dr. Peter Goodwin was an Associate Professor (now professor emeritus) in the Department of Family Medicine at the Oregon Health Science University in Portland, Oregon and was Chair of Oregon Right to Die during the campaign to pass Oregon's assisted-suicide law. He had been active in the Hemlock Society. Speaking at a 1993 Hemlock conference in Orlando, Florida, he explained that he favored both the lethal injection and assisted suicide, but he realized that most people were not yet ready to accept the former so incremental steps would need to be taken.

[28] Erin Hoover and Gail Hill, "Two die using suicide law; Woman on tape says she looks forward to relief," *Oregonian*, March 26, 1998; Kim Murphy, "Death Called 1st under Oregon's New Suicide Law," *Los Angeles Times*, March 26, 1998; and Diane Gianelli, "Praise, criticism follow Oregon's first reported assisted suicides," *American Medical News*, April 13, 1998.

[29] N. Gregory Hamilton, M.D. and Catherine Hamilton, M.A., "Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report," presented at the American Psychiatric Association Annual Meeting, New York, New York, May 6, 2004. (http://www.pccef.oorg/articles/art28.htm)

[30] ORS 127.825 §3.03.

[31] Andis Robeznieks, "Assisted-suicide numbers in Oregon," *American Medical News*, April 5, 2004.

[32] *Supra* note 8.

[33] Ibid.

[34] Oregon Health Services Commission, "Current Prioritized List of Health Services," Jan. 1, 2007, p. 30 of 114 and p. 87 of 114. (http://www.oregon.gov/DAS/OHPPR/HSC/docs/Jan07Plist.pdf)

[35] Jonathon Oberlander, "Health Reform Interrupted: The Unraveling of the Oregon Health Plan," *Health Affairs*, Dec. 19, 2006.

[36] *Supra* note 34.

[37] ORS 127.800 §1.01(12), ORS 127.815 §3.01 (a), and ORS 127.820 §3.02.

[38] *Supra* note 29.

[39] Department of Human Services (DHS), Oregon Health Division (OHD), "Oregon's Death with Dignity Act: The Second Year's Experience," February 23, 2000, Table 2. (http://www.ohd.hr.state.or.us/chs/pas/year2/ar-index.cfm)

[40] Katrina Hedberg *et al*, Letter to the editor in response to "The Oregon Report: Neutrality at OHD?" *Hastings Center Report*, January-February 2000, p. 4.

[41] Testimony of Jim Kronenberg, *HL*, p. 312, question 842.

[42] Compassion and Choices of Oregon web site (http://www.compassionoforegon.org) last accessed Apr. 23, 2007.

[43] Testimony of Peter Rasmussen, *HL*, p. 312, question 842. (Emphasis added.)

[44] ORS 127.840 §3.06 and ORS 127.850 §3.08.

[45] *Supra* note 8.

[46] Testimony of Dr. Katrina Hedberg, *HL*, p. 257, question 555.

[47] Amy Sullivan, Katrina Hedberg, David Fleming, "Legalized Physician-Assisted Suicide in Oregon – The Second Year," 342 *New England Journal of Medicine* (February 24, 2000), p. 603.

[48] *Supra* note 9.

[49] Andis Robeznieks, "HMO query reignites assisted-suicide controversy," *American Medical News*, September 9, 2002.

[50] Ibid.

[51] Ibid.

[52] Transcript of tape of Peter Goodwin, "Oregon" January 11, 2003, presented at 13th National Hemlock Biennial Conference, "Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill," January 9-12, 2003, Bahia Resort Hotel, San Diego California.

[53] "Compassion in Dying of Oregon Summary of Hastened Deaths," Data attached to Compassion in Dying of Oregon's IRS Form 990 for 2003.

[54] Testimony of Dr. Elizabeth Goy, *HL*, p. 291, question 768. (Goy is an assistant professor, Dept. of Psychiatry, School of Medicine, OHSU, and has worked with Dr. Linda Ganzini in formulating results of surveys dealing with Oregon's law.)

[55] ORS 127.835 §3.05.

[56] ORS 127.860 §3.10.

[57] Testimony of Dr. Katrina Hedberg, *HL*, p. 267, question 620. (Emphasis added.)

[58] Testimony of Sue Davidson, *HL*, p. 357-358, question 1098.

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